

PHILADELPHIA MEDICAL TIMES.

PHILADELPHIA, SEPTEMBER 14, 1878.

ORIGINAL COMMUNICATIONS.

TWO CASES OF OPIUM-POISONING —FAILURE OF ATROPIA TREAT- MENT.

BY FRANCIS L. HAYNES, M.D.,

Assistant-Surgeon to the Episcopal Hospital.

I.—HALF AN OUNCE OF LAUDANUM SWALLOWED AND RETAINED—RECOVERY.

SAMUEL S., aged 50, a weaver, was a man of eccentric character and intemperate habits. He had been for years afflicted with phthisis, and was greatly emaciated. On August 9, 1878, during a debauch, which had commenced five days previous, he swallowed half an ounce of laudanum. Vomiting did not occur at any time. The preparation was not the official one, but I was assured by the very careful apothecary from whom it was purchased that it contained the active principle of nine grains of opium (to the half-ounce of menstruum). The patient was taken to a police-station, and was treated by electricity and forced exercise. I did not see him until 4½ hours had elapsed.

4½ hours.—He was very sleepy, but could be awakened by shaking; he answered questions, and could walk, with the assistance of two men. He would not swallow, or allow the stomach-pump to be used. Respiration 6, somewhat stertorous; pulse 156, weak; pupils—right one-half dilated, left extremely contracted; both immobile. Atropia sulph. gr. ⅙ was injected under the skin. He was aroused at intervals by shouting, whipping, and shaking, and by forcing him to walk, but did not breathe more frequently when awake. The stertor disappeared when he was awake.

5 hours.—Condition the same. Atropia sulph. gr. ⅙ injected.

5½ hours.—He could scarcely be awakened. When attempts were made to exercise him, his legs "doubled up." Respiration 5, stertorous; pulse 158, weaker.

5¾ hours.—Atropia sulph. gr. ⅙ injected.

6 hours.—He could not be aroused. The left pupil was somewhat larger; the right was of the same size as at 4½ hours. Respiration and pulse same as at last note. Atropia sulph. gr. ⅙ injected.

6¼ hours.—Respiration 5, stertorous; pulse 160, very weak. Left pupil still larger; right continued at same diameter.

6½ hours.—He was completely comatose. Respiration, pulse, and pupils the same. Atropia sulph. gr. ⅙ injected.

8 hours.—He was apparently dying. The lips were blue, the surface cold and clammy, the eyes turned up. Respiration 4, very noisy; pulse almost imperceptible, and so frequent that it could not be counted. The left pupil

had dilated to the same extent as the right, which retained its original diameter. He remained in this condition for half an hour, then gradually improved.

9¼ hours.—He could be readily aroused. Respiration 5, less stertorous. Pupils and pulse same as when last noted.

15½ hours.—He was awake and troubled by hallucinations, but was occasionally sensible. Respiration 11, quiet; pupils same; pulse 144.

24 hours.—Delirium since last note; sleeplessness; dryness of throat. Respiration 20; pulse 140.

43 hours.—He was still sleepless, and was troubled at times by hallucinations. A sleeping-draught was ordered.

From this date the history of the case is one of pneumonia occurring in a consumptive. He succumbed August 18.

The total quantity of atropia sulph. given was gr. ⅙.

Remarks.—Atropia was not given in this case as an antagonistic poison, but as a stimulant to the respiratory centres. During its use all the symptoms were aggravated; and one and three-fourths hours elapsed, after the last dose, before any improvement occurred.

Atropia is supposed to be beneficial in opium-poisoning—(1) by antagonizing in some mysterious and undefined way the action of opium, just as quinia antagonizes the action of malaria on the system;* (2) by causing the dilated and paralyzed vessels of the brain and spinal cord to contract, and thus obviating death by congestion or oedema of these organs;† (3) by stimulating the heart, and preventing death by cardiac exhaustion;‡ (4) by stimulating the respiration, and thus combating the most frequent cause of death in narcotic poisoning,—failure of respiration.§

In this case the atropia had an opportunity to act in any of these ways. The dose was large enough to act as an antagonistic poison,|| and not too large to act as a cerebral vaso-motor, a cardiac, or a respiratory, stimulant.

For the history of the following case I am indebted to Dr. Todd, of West Point, Ga. It has not, I think, been published hitherto.

* Norris, Am. Journ. Med. Sci., Oct. 1862; Johnston, Med. Times and Gaz., Sept. 7, 1870, p. 268.

† Bennett, Antagonism of Medicines, Lond., 1875, p. 46.

‡ Harley, Old Vegetable Neurotics, p. 309.

§ H. C. Wood, Am. Journ. Med. Sci., April, 1873, p. 339.

|| Nine grains of opium, the dose taken in this case, are about equal to one grain of morphia, a dose which is sometimes used therapeutically, by the mouth, or injected under the skin. According to the ordinary doses employed, gr. 4-19 of atropia should at least equal as a poison the above-mentioned dose of morphia.

II.—ONE OUNCE OF OPIUM TAKEN—A PORTION
VOMITED—DEATH.

B. R., aged 56, a merchant, had been at intervals for eighteen months a sufferer from attacks of insanity, during which he had attempted by various means to commit suicide. On December 20, 1872, he ate one ounce of gum-opium.

1 hour afterwards.—He was slightly sleepy. Refused treatment.

2 hours.—The drowsiness was increasing. Vomiting of a quantity of opium followed the administration of sulphate of zinc, through the nose, by means of a funnel and catheter. Forced exercise was used. Hypodermic injections of veratrum viride tincture, eleven drops in a drachm of whisky, were commenced, and continued at intervals of half an hour.

7 hours.—Hitherto the patient had not been very drowsy. He had given rational answers to questions; the respiration had not fallen below 14, or the pulse below 65, a minute. The pupils had not contracted. "At this time Dr. X., the family physician, arrived, and only one more dose of veratrum viride was given. The patient recognized Dr. X. Dr. X. counted his pulse and respiration, which were as given above. We commenced to use the cold douche.

"7½ hours after the ingestion of the poison we commenced to inject atropia under the skin, in doses of gr. $\frac{1}{10}$. This was repeated every fifteen minutes. From the first dose the coma deepened and the respiration became less frequent.

"8 hours and 20 minutes.—The pupils began to dilate.

"8½ hours.—At this moment, precisely, he ceased suddenly to breathe. The heart continued to beat 65 a minute for several minutes after the breathing had ceased. Artificial respiration and electricity were tried, but in vain."

Remarks.—Atropia certainly did not stimulate the respiration in this case, the patient dying from failure of that function. (It is not certain, from the notes, whether four or five doses were injected; but probably only four, as respiration ceased just as the moment came for the fifth injection. The state of the pupils, though this is not a very important point, is not very satisfactorily indicated.)*

* The subject is one of such importance that the editor of the *Times* takes the liberty of pointing out that, according to his reading, these cases do not disprove the value of atropia in opium-poisoning. In the last case the patient took the equivalent of nearly thirteen ounces of laudanum: of course in immediate evacuation of the stomach lay the only chance of escape. In the first case, apparently, not enough of atropia was used to so far counteract the effect of the laudanum as to produce any immediate effect. Only after the lapse of some hours does the report afford any indication of belladonna symptoms. There can be no definite relative dose of the two poisons, as different individuals offer very different susceptibility to the two narcotics.

SUCCESSFUL CASE OF TREPHIN-
ING FOR EPILEPSY.

BY PROF. D. HAYES AGNEW.

(Reported by W. HOBSON HEATH, M.D., Ex-Resident Surgeon University Hospital, Resident Physician Philadelphia Hospital.)

M R. R. B. S., æt. 45 years, was wounded in Tennessee on January 1, 1863, by a piece of shell which exploded about twenty feet above him, a fragment striking him upon the top of the head and chipping off a piece of skull. He lost consciousness for about an hour, was taken to a hospital and placed with other wounded. No evidence of compression. The injury was not followed by any inflammation of the brain or meninges, although the wound was attacked by erysipelas two weeks after. He rejoined the Confederate army eight months after receipt of the injury, during which time several fragments of bone were discharged; his health otherwise being perfect. The first attack of epilepsy came on suddenly before breakfast, six years later (1869), upon a damp, inclement morning. There was no distinct aura; the fit was violent, and the following stupor deep, and it was the most violent of all his seizures. The cicatrix had never given any neuralgic trouble or become inflamed.

Two months later a second seizure occurred of the same character, and very severe, and up to the present time they have recurred at periods varying from one to six weeks. At one time they were held in check by large doses of the "bromides." The past year the attacks have been preceded by an aura, which commences on the inner and under side of the arm near the wrist; and sometimes at the tips of the little and ring fingers, and is described as a sleepy, numb feeling. The disease has seriously interfered with his business, impaired his mind and memory, especially during the past two years, and on several occasions jeopardized his life.

General health good, habits excellent, is married, and children healthy.

Parents healthy, and habits good. No history of epilepsy in family.

Examination of head shows a cicatrix two and three-quarter inches long over right parietal bone. The cicatrix is depressed one and three-quarter inches of its length at one end. Depression measures one and a half inches in length at the bottom, one-third of an inch wide, one-third of an inch deep.

This patient had been in the hands of many of the best physicians in the South, without relief. He applied to Prof. Agnew for surgical interference to remedy his condition. He was kept quiet for a few days, and his general condition was looked after; had no fits for thirteen days prior to admis-

sion. At the time of operation he was etherized, his head was shaved, and a crucial incision made over the cicatrix, each flap being dissected off from the pericranium. The somewhat free hemorrhage was controlled by the flaps being held and the vessels compressed by the assistants. The trephine, an ordinary fluted one, the size of a twenty-cent piece, was applied over and included one end of the depression, and was very slowly worked. It was some twenty minutes before the skull was sawed through, and then upon examination it was found to have been perforated only at one-half of the circumference of the trephine. This irregularity was due to the fact that the bone, especially the inner table, had become hypertrophied at and around the point of injury, and the point first sawed through was where the process had been less—farthest off from the injured portion of bone.

Examination of the pieces removed and of the skull itself showed that there was no depressed fracture at all; that the injury sustained by the bone was simply the chipping off of a piece from the outer table; that, in consequence of this, the bone, particularly the inner table, had become hypertrophied, the thickest part being apparently around the injury, and therefore the pressure upon the brain was general over a surface probably many inches around. Two discs of bone, which included the *depression in the bone*, were removed, and showed the condition stated, and also that the increased thickness was of such extent that it was not thought prudent to remove it entirely. The fact that frequently in trephining the instrument passes through to the dura mater at one point before it does at another (and it was so especially in this case, though from pathological reasons) suggested to Prof. Agnew the idea of having a trephine serrated only on a portion of its circumference, the remainder being smooth. Such an instrument could be used without injury to the membranes where they were exposed, and in the present case would have been very useful. On removing the pieces of bone the membranes were found uninjured, and there was no trace of previous inflammation. The flaps were closed over the wound, but no stitches or adhesive plaster applied to keep them in place, and thereby exert any pressure or obstruct the drainage. The treatment then ordered was a plain water-dressing locally, and calomel $\frac{1}{2}$ grain, opium

$\frac{1}{6}$ grain, every two hours, with an occasional dose of bromide of potassium, if restless, milk diet, elevation of the head, and perfect quiet.

Patient came out of ether nicely, and did not vomit; complained slightly of headache; had no chill, no increase of temperature, and slept well under bromide of potassium until the next morning, when he was taken with a convulsion, not very severe or long, which was attributed to the operation.

The case after this did remarkably well. There was no inflammation of the brain or meninges, though it was expected to follow.

The temperature during the first week arose to 100° twice; after that it remained at 98° , 99° , until the patient was discharged. The pulse, never above 100, and averaging 90, was throughout soft and regular. The tongue was slightly furred, due to the irregularity of the bowels and confinement. The constipation was obstinate, owing to the recumbent position and a natural torpid habit. Seidlitz powders and the occasional judicious administration of an enema only were used.

The appetite was good after the first four days.

The most annoying symptom complained of throughout was headache. This was constant and frontal,—right over the eyes; it diminished after the first week, and assumed an intermittent character, being produced, apparently, or influenced most by constipation. At one time it appeared like neuralgia of the supra-orbital nerve, and aconitia ointment was applied, and gave relief.

Bromide was given throughout the treatment; the calomel and opium were discontinued after the first week. The wound was dressed with plain water-dressing, and nothing was allowed to interfere with free drainage. After the granulation reached the level of the scalp, the edges of the flaps were gently approximated by strapping.

At the end of twenty days he was allowed to sit up in bed, and by the thirty-second day to get out of bed, remaining up longer day by day.

The operation was not followed by any exfoliation of bone.

The patient was discharged six weeks after operation, to return to the South.

This makes the second case of trephining for epilepsy by Prof. Agnew at the University Hospital, within two years, with

the recovery of both patients and the disappearance of the malady.

The most peculiar and interesting feature in this case was the general thickening of the bone around the seat of injury and the relief by the operation, though the entire amount thickened and pressing upon the brain was not removed.

The rapid and uninterrupted convalescence is worthy of note, considering his age and condition, and the gravity of the operation.

UNGUENTUM HYDRARGYRI OXIDI FLAVI.

BY J. T. WALKER, M.D., PH.D.

IN the *Medical Times* of July 20, 1878, there appeared an article written by Dr. Landesberg condemning the above ointment, for its non-stability and difficulty of preparation, in the following language: "1st, it is *very liable* to decomposition; 2d, it is very hard to *triturate*. Whatever constituents may be used for the ointment, decomposition sets in sooner or later. The ointment, which, if properly attended to, is of a fine yellow color, becomes, after a short time, dirty yellowish, smells rancid, and loses its healing power."

He says further, "How difficult it is to *triturate* the yellow oxide of mercury is proved by the fact that the correct composition of the ointment is found with only few druggists," etc.

How the doctor could arrive at the above conclusions is difficult for one to understand, unless he has repeatedly fallen into the hands of ignorant or unprincipled druggists.

In the first place, the ointment is not very liable to decomposition if made with suitable material; secondly, it requires no *trituration*, as the yellow oxide is an amorphous powder, prepared by precipitation, showing no crystalline structure even under the microscope; in this respect totally unlike the red oxide.

On the 24th ult. (more than four weeks ago), Mr. D. H. Latham, Jr., prepared for me the following ointments (all of which are in a good state of preservation), taking no more than ordinary care in preparing them, and taking special care to give them the usual exposure by removing the lids from the jars daily and allowing access of

air. They were dispensed in an ordinary half-ounce glass jar with a wooden lid, the same as used by most apothecaries in dispensing ointments.

No. 1.

R Hydrargyri oxidi flavi, gr. xxx;
Unguenti benzoini (U.S.P.), 3iiss.

No. 2.

R Hydrargyri oxidi flavi, gr. xxx;
Unguenti petrolei (Cosmoline), 3iiss.

No. 3.

R Hydrargyri oxidi flavi, gr. xxx;
Unguenti aquæ rosæ, 3iiss.

No. 4.

R Hydrargyri oxidi flavi, gr. xxx;
Unguenti aquæ rosæ, 3iiss;
Balsam. Peruv., gtt. iii.

No. 5.

R Hydrargyri oxidi flavi, gr. xxx;
Unguenti cum oleo ricino, 3iiss.

It will be observed that the amount of yellow oxide used is greater than ordinarily prescribed, which would be more favorable than otherwise for oxidation. No decomposition has yet taken place in any of the ointments, but of course would in time, with the exception probably of that made with *cosmoline*, it being no doubt by far the best material for all ointments, and should be preferred where an ointment would be required to be kept a very long time; but a month is quite as long, even longer, than any physician expects a patient to use an ointment without renewal.

No. 3 was made with cold cream (rose-water omitted). This cold cream was not made for the oxide of mercury ointment, but was taken from some that had been made two weeks, the object being to use no more than *ordinary* care in preparing and selecting material, so as to come to an impartial conclusion concerning the above ointments.

No. 4 was made with same cold cream (U. S. P. formula), minus rose-water.

No. 5 was made from a recipe furnished by Mr. Henry A. Bower (*vide Journal of Pharmacy*, Phila., vol. xlii. p. 303). An ointment of the red oxide of mercury, prepared thus, I have seen keep for six months without undergoing any change. This probably is almost as permanent as *cosmoline*. The following is the formula:

R Hydrargyri oxidi rubri (vel flavi), 3x;
Olei ricini, f3i;
Adipis (lat.), 3vii;
Ceræ flavæ opt., 3ii.

Melt the wax and lard together, and mix

with the castor oil. On cooling, add the precipitate in very fine powder, stir constantly with a wooden spatula until cold. From the above experiments I am convinced that no one is worthy of the title apothecary who cannot furnish a satisfactory ointment of yellow oxide of mercury.

201 COLUMBIA AVENUE, PHILA.

CHLORAL HYDRATE AND OXIDE OF ZINC IN ACUTE INTESTINAL DISEASES OF CHILDHOOD.

BY JAMES L. TYSON, M.D.

HIGH heat for the past six or eight weeks, together with the irritation of dentition and improper diet, or over-feeding, or both, have been prolific factors in the generation of that troublesome and not rarely fatal malady among children, in ordinary parlance cycloped summer complaint, whether it presents itself under the form of simple diarrhoea, cholera infantum, entero-colitis, or dysentery. Though the unwholesome atmosphere of a city in hot weather contributes largely to its production and fatal result, I am inclined to think that unsuitable food and too much of it may in the country, from my observation of both localities, be pronounced almost as frequent a cause of its prevalence and fatality there as are the foul airs in the crowded alleys of a populous town. At all events, it has prevailed to a considerable extent in this county, and, as I have had a good many cases under my care, some of which were almost *in extremis* when first seen, I have been urged to present a brief abstract of the treatment instituted, though by no means new to many, which in my hands has resulted so satisfactorily. I am more particularly induced to refer to it now, from having read a note addressed to the editor of the *Medical Times*, by Dr. W. L. Newell, of Millville, New Jersey, announcing the benefits which resulted from chloral enemata in his and his colleague's hands in cases of dysentery in adults. It is the employment of this agent in that form, along with other treatment, among children within the year,—say from six to nine months old,—whose claims to consideration I advocate and desire to enforce with all the earnestness that its merits demand. I was much gratified to learn from Dr. Newell's note that his treatment for adults so fully vindicated

my preconceived impressions of its utility in cases of children. Simple attacks of the complaint in this vicinity readily yielded to a change or diminution of diet, and a cold bath two or three times a day. Others were of a much graver type, the discharges being lienteric, mixed with blood or bloody water, from twelve to twenty occurring in the course of a day, and in some cases the tenesmus so excessive that the moment an enema was administered it was expelled. This spasmodic action of the sphincter and lower bowels could only be controlled by repeated resort to the remedy, two or three applications being requisite before it could be retained, and then only by directing the nurse or mother to compress the glutæi muscles on either side, close over the anal orifice, for two or three minutes. When thus kept in immediate contact with the inflamed, sensitive, and irritable tissue, the benefits were prompt and enduring. Tenesmus, or choreal spasm of the bowel, was arrested, pain and inflammation were allayed, and the little sufferer would rest or sleep comfortably for several hours. A repetition of the enema was made once, sometimes twice, in the twenty-four hours, with increased comfort and alleviation of all the symptoms.

In cases of this kind, as well as others, of course great attention was paid to the preparation of food, so that entozoa, infusorial, or bacterial spores in the fluid used were thoroughly *sterilized*. To accomplish this the milk was added to *boiling water* containing a little gelatin and arrow-root. The milk should not be boiled. A teaspoonful of lime-water should be put in every teacupful of this preparation, which should always be given cold. The amount of chloral used in each application was about two grains dissolved in one or two teaspoonfuls of starch water.

Along with this local treatment, two grains of oxide of zinc and three of lactopeptine in mucilage were given every five or six hours. This combination exerts a happy influence on the *primæ viæ*, enabling the child to digest its food more thoroughly, and controlling the number while it alters the character of the evacuations in a day or two. We are indebted to Dr. Brackenridge, of Edinburgh, for having first suggested the use of oxide of zinc in these maladies of children,—a detailed statement of cases in which he had successfully employed it being pub-

lished,—and to a more recent article in the *Glasgow Medical Journal* by Dr. I. Crawford Renton and inserted in the last number of *Braithwaite*. Some of the cases in which the foregoing treatment was carried out were of a desperate, apparently hopeless, character, but in all benefit was soon apparent, and the little patients recovered. In no instance was any preparation of opium or calomel resorted to; but I can well understand the advantages claimed for minute doses of mercuric chloride in a well-written article on "Acute Intestinal Catarrh of Infants," from the pen of Dr. Rudolph Ravenburg, of Washington, D.C., published in a recent number of a New York medical journal; and many cases might occur in which its employment, alone or in conjunction with the treatment already detailed, might be clearly indicated.

Subjoined are the formulas used in the cases referred to.

I may add that the cold bath three times a day was invariably insisted upon, but never at a lower temperature than 80° to 85°.

R Chloral hydrate, 3ss;
Starch water (amylum), ʒij.

M. Ft. solut.

Sig.—Enema. One to one and a half teaspoonfuls to be *thrown* into the bowel from a small glass syringe.

R Zinci oxidi, 3ss;
Pulv. g. acaciæ et sacch. alb., aa ʒij;
Lactopeptin, ʒj;
Aq. cinnam., q. s. ut ft. ʒi.

M. S. A.

Sig.—A teaspoonful every five or six hours.

MONTGOMERY COUNTY, August 16, 1878.

A SINGULAR CASE OF INFANTILE CONVULSIONS.

BY J. F. WALSH, M.D.

AUGUST 22, 1878, I was called in great haste to see M. C., æt. 6 years, when I found the boy in violent convulsions. He was apparently a healthy lad, and on inquiring into his previous history I learned that he had never been subject to fits, nor had he ever had any serious sickness. He had never been troubled with worms.

His mother said that he had been found, about two hours previous, in an open lot in front of a grocery-store, in an insensible condition. Strewed around him was a quantity of spoiled raisins which the grocer had thrown out. He was taken into the store, where he

vomited a few raisins. About a half an hour later, 11½ A.M., he was removed home. My office-hours not commencing until 1 P.M., the family did not send for me until that time. In the mean while he had been in a state of almost continuous eclampsia, having but few remissions. He had not been given any medicine before my arrival; all the mother did was to put him in a warm bath, which, however, did not relieve the symptoms.

When I got to the house his condition was as follows. Whole body convulsed. Unconscious. Cheeks dusky red,—face bathed in sweat. Pupils dilated and insensitive to light; strabismus. Breathing labored. Heart acting very irregularly, fast (one hundred and fifty per minute), and feebly. Slight frothing at corners of mouth. Grinding of teeth. Belly tympanitic.

Believing that the raisins he had eaten were the source of the trouble, I administered, about fifteen minutes after my arrival, during a remission, three teaspoonfuls of wine of ipecac. About a half an hour later he was seized with violent vomitings, and threw up a large quantity of partially-chewed raisins. Immediately the convulsions ceased, he went off into a quiet sleep, and subsequently awoke quite well.

CAMDEN, N.J.

NOTES OF HOSPITAL PRACTICE.

COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

CLINIC OF PROF. A. JACOBI, FOR DISEASES OF CHILDREN.

(Reported by P. BRYNBERG PORTER, M.D.)

Concluded from p. 560.

HEREDITARY SYPHILIS, WITH OSTEITIS AND PULMONARY INFILTRATION.

ROSANNA G., 9 years of age. Since she was one year old the child has suffered from glandular lesions about the neck and throat, and several times abscesses of this character have been lanced. Up to two years ago she had no nasal catarrh, as far as can be ascertained, but since then she has been very seriously troubled in this manner. There has been an almost constant discharge of pus and blood, with particles of decayed tissue,—and almost from the first, the mother says, the septum of the nose has been affected. The nasal bones have also become implicated, and you notice that there is now considerable deformity resulting. No very clear history of syphilis can be obtained from the mother, as she denies ever having had the ordinary symptoms, but the fact that she has had no less than six miscarriages would leave little ground for doubt that the child now before

us is suffering from hereditary syphilis. One other child besides this one was born at full term, but is now dead. The mother says that it never had any eruption on it. One of the abortions was at the eighth month, and all the others at a considerably earlier period of gestation. Nothing is known in regard to the father.

Perforation of the septum of the nose is almost universally regarded as an evidence of syphilis. Ordinarily, I believe that it is, but at the same time I have seen several instances in which this was not the case. Sometimes the ulceration from which perforation finally results is very superficial at first, but, on account of the peculiar character of the cellular tissue, it goes on slowly increasing in extent and depth. A perforation originating in this manner is usually in the lower part of the septum. Osteitis and periostitis are very common manifestations of hereditary syphilis, and where syphilis has been partially arrested in the parent, bone-disease is frequently the only evidence of the affection seen in the child. Osteitis is more often met with than periostitis in hereditary syphilis, while the latter, as you know, is more commonly met with in the acquired syphilis of the adult.

There is another feature of this case which is quite striking, and that is the unusual prominence of the veins of the neck. This undoubtedly indicates some trouble either with the lungs or the heart, and we will, therefore, proceed to make an examination of the thorax. When the child is stripped you perceive that she is considerably emaciated, and percussion shows that there is marked dulness over a considerable portion of the chest upon both sides. This is more marked over the lower part of the left lung posteriorly and the upper part of the right lung anteriorly. This is certainly not due simply to any pleuritic trouble; for if that were the case there would not be so much obstruction to the circulation as we find present here. On auscultation it is found that there is diminished respiration over a great part of the chest, with some rude breathing at the right apex. When we examine the heart we find that the area of cardiac dulness is much increased, extending farther to the right than normal, and that there is increased shock, while the apex-beat is more to the right than usual. There is, therefore, hypertrophy of the right heart, as we would naturally expect from the condition of the lungs,

which is no doubt chronic; and this is due to the fact that it has more work to do than if the lungs were healthy.

It seems, then, altogether probable that we have to deal here with a specific infiltration of the lungs, and that this has probably existed for years. This condition not infrequently leads to phthisis, and I have not the slightest doubt that a considerable number of cases of phthisis, especially in the cities, originate in the same manner. Hence it is that physicians who are accustomed to meet this class of cases, and who have seen such good results follow a course of mercurial treatment as is frequently the case, have got the idea that mercury is beneficial in all sorts of phthisis. Such, as it seems to me, must be the basis of the opinion that a mercurial treatment is of service in phthisis, and this is, of course, an error; for, while the use of mercury constitutes the best treatment for syphilitic phthisis, it would be about the worst sort of treatment for ordinary tuberculosis.

Our diagnosis in this case, therefore, is syphilitic osteitis and periostitis, with syphilitic pulmonary infiltration; and, under the circumstances, it becomes necessary for us to adopt a persistent but careful course of treatment by mercury. The iodide of mercury produces so much irritation of the alimentary tract as to render its use highly objectionable, and, though the action of calomel is considerably more mild, it is liable to cause too much laxity of the bowels. The bichloride will probably be the best form in which to give the mercury here, and the fortieth or fiftieth of a grain will be about the right dose for the child. Thus, we may order a prescription of one grain of the bichloride to five ounces of water (with a little syrup, if you choose), and of this the child should take a teaspoonful three times a day, about an hour after eating. With this a mouth-wash, composed of half an ounce of chlorate of potassium to the pint of water, should be ordered, and the latter may be employed ten or fifteen times through the day. The gums should be watched carefully, although salivation does not result so frequently in children as in adults who are taking mercury. Still, the drug sometimes produces unpleasant results, and its effect should always be noted with care. If our diagnosis is really correct, and the treatment is faithfully carried out, in the course of two

or three months we ought to expect to find considerable improvement in the condition of the lungs, and, as a result of that, a diminution in the size of the jugular veins.

PROLAPSE OF THE RECTUM.

The last patient whom I shall show you to-day, gentlemen, is a little boy three and a half years old. The mother states that somewhat more than a year and a half ago she noticed that the bowel began to protrude after defecation. The tumor thus formed by it soon became as large as an egg, and is now of even considerably greater size than that. It was formerly of a deep-red color, but is now of a much paler hue. It is a significant point in the history, that the child suffered from diarrhoea during all the summer preceding the prolapsus.

The mother tells me that during this time he often had ten and twelve movements of the bowels in a day, and that the evacuations were copious and passed without straining. The last fact would seem to indicate that there was no local cause for the diarrhoea, like a catarrh of the rectum. In this condition there is an over-secretion of mucus and serum, and sometimes a little blood is passed, whence it is frequently described as catarrhal dysentery.

It is probable that there is no polypus here, but that we have to do simply with a well-marked prolapsus of the rectum. When the bowel thus habitually protrudes after defecation, certain changes take place in its walls. There is a swollen condition of the follicles, and also of the mucous membrane, which becomes much thickened, and there is a rapid throwing off, as well as reproduction, of the epithelium. There is an increased secretion of mucus, as one would naturally suppose, and not infrequently there is some paralysis resulting. When the bowel has come down a number of times, the sphincter ani muscle grows accustomed, as it were, to the protrusion through it, and the bowel becomes swollen all the more after passing it.

In a recent case of prolapsus of the rectum the injection of ice-water is often sufficient to effect a cure, but where this fails we may resort to zinc or alum. One of the best applications is the nitrate of silver, either in stick or in solution of greater or less strength. In whichever form it is employed (and even if only a weak solution is used), it should be immediately neutral-

ized, because otherwise it is almost certain to give rise to extreme tenesmus, and when this occurs it only aggravates the difficulty instead of assisting in its removal. Finally, the actual cautery can sometimes be used with good effect in these cases; and when there is only a paralysis of the sphincter ani, there is nothing of so much service as *nux vomica* or *strychnia*.

Where we have the opportunity (as in private and hospital practice), the most prompt and efficient method of accomplishing a cure, by means of the latter, is to employ it hypodermically, using about the one-sixtieth of a grain every day in this manner.

In this case, when we come to look at the parts to-day, we see that the bowel is now entirely up within the anus. On introducing my finger, after oiling it, into the rectum, I find that there is no polypus present, but that the bowel is everywhere soft and flabby. When the child has a passage, the mother says, the bowel begins to come out before the *fæces* appear; and this shows that the sphincter is not in a condition to withstand any pressure upon it. When the rectum is down it protrudes fully three inches from the body, she tells me. By way of treatment here I shall order, in the first place, a large injection of cold water every night and morning, which will have the effect of keeping the passages soft, and so less liable to force the bowel down, and will also, I trust, give more tone to the rectal walls. In addition, I will advise the use of an ointment composed of a drachm of the alcoholic extract of *nux vomica* rubbed up with an ounce of fat. Of this the mother is to apply a piece about the size of a bean whenever the bowel comes down, or three times a day whether it protrudes or not.

TRANSLATIONS.

BLOODLESS OPERATIONS UPON THE TONGUE.—Langenbuch (*Cbl. f. Chirurgie*, 1878, p. 400; from *Arch. f. Klin. Chir.*) operated in two cases, as follows. The tongue being drawn as far as possible out of the mouth, a long curved needle, armed with a thread, was inserted perpendicularly into the back of the tongue in the median line, some two or three centimetres back of the posterior boundary of the tumor. From

there the needle was carried at a right angle to the long axis of the tongue circularly around towards the ramus of the jaw, and then, penetrating through the mucous membrane of the floor of the mouth, was brought back into the oral cavity. In order to give the loop as immovable a position as possible around the muscular tongue, the right border of the tongue was included by the needle in bringing it out. The other half of the tongue was included in the same manner. The ligatures included in each case a little of the tissues on the other side of the median line; they were drawn together and knotted, the ends, which hung out of the mouth, serving to draw out the tongue. Thus the operation could be performed without loss of blood. x.

SYMPTOMS AND TREATMENT OF PSORIASIS UNIVERSALIS.—Kaposi (*Cbl. f. Chirurgie*, 1878, p. 406; from *Wien. Med. Wochens.*) depicts the appearances presented by psoriasis universalis where the efflorescence is interrupted by very small islands of sound skin or by none. Under these circumstances the affection may easily be mistaken, by those unaccustomed to the diagnosis of skin diseases, for pemphigus foliaceus, lichen ruber, or pityriasis rubra. Even specialists may sometimes confound this form of psoriasis with eczema universale. While until recently prognosis of such cases has always been unfavorable, Kaposi has of late succeeded, by the employment of cod-liver oil, of inunction, of baths, and of caoutchouc clothing, in obtaining very good results,—that is, of temporary cure. For instance, cases are on record where, after a course of cod-liver oil, terrible eruptions of eczema followed the psoriasis. In these cases care must be taken to stop the oil in due time. Continuous baths, also envelopment in bandages covered with ung. diachylon, prove useful in these cases. x.

INJECTION OF TINCTURE OF IODINE INTO THE KNEE-JOINT.—Orlow (*St. Petersb. Med. Wochens.*, 1878, No. 12) has in ten cases punctured the synovial sac, drawn off the fluid, and injected dilute tr. iodine (1 to 3 parts water). After a few moments a portion of the injected fluid was allowed to escape. The reaction was not severe, the patients were treated in the out-patient clinic, and needed no further treatment. Eight of the cases were of serous synovitis, and two of gonitis sero-purulenta. x.

UTERINE MYOMA—SUBACUTE PERITONITIS FOLLOWING SIMPLE VAGINAL EXAMINATION—DEATH.—A. Poncet (*Cbl. f. Chir.*, 1878, p. 391; from *Gaz. Méd. de Paris*) had under his care a woman suffering from a voluminous uterine myoma. A few hours after a simple vaginal examination had been made, the patient was attacked by peritonitis, of which she died within forty-eight hours. Notwithstanding the fact that the various symptoms of peritonitis, swollen abdomen, severe pain upon the slightest pressure, continual vomiting, etc., were present, the post-mortem examination showed no signs of inflammation, excepting some four to five hundred grammes of sero-sanguinolent fluid in the cavity. The author considers the case one of septic peritonitis. x.

PENETRATING WOUND OF ABDOMEN—RECOVERY.—Pierantoni gives the case of a girl of 18 who received a penetrating wound of the abdomen. The intestines protruded and were wounded, and the external wound bled considerably. The wound of the intestine was sewn up, and then the abdominal wound was closed. A few days later, meteorism, vomiting, etc. The wound came open and some masses of feces escaped. After this the patient's progress was favorable, and she was quite well within twenty-six days from the operation. x.

PREVENTION OF HEMORRHAGE AFTER THE USE OF ESMARCH'S BANDAGE.—It is generally regarded as one of the chief drawbacks to the employment of Esmarch's bandage that hemorrhage, often of an exceedingly stubborn character, is so apt to occur after operation. M. Riedinger has sought to avoid this unfortunate complication by the use of the induced current. This appears to possess the property of arresting consecutive hemorrhage even when ischæmia has existed some time, a result which seems to depend upon the contraction of the muscles and of the vascular walls. R.'s procedure is as follows. Having finished the section of the tissues and tied all attainable vessels, he submits the wound to the influence of the induced current, the electrode being armed with a sponge, for some moments, and then, removing the tube of the Esmarch's apparatus, secures those vessels which continue open. His success in numerous cases has been very satisfactory.—*Le Mouvement Méd.*, 1878, p. 263; from *Arch. Méd. Belge*. x.

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EDITORIAL.

MARINE HOSPITAL SERVICE.

THE report of the Supervising Surgeon-General of the Marine Hospital service, Dr. Woodworth, which is just at hand, contains much matter worthy of the study of every one interested in the hygiene of water transportation, or of sea or fresh-water ports. On the whole, it is an earnest, manly document, and its suggestions seem to be worthy of most careful consideration. We have one criticism, however, to make. In an official report, and especially in one discussing proposed measures of reform, the tone should be not so much that of advocacy as of calm, judicial weighing of advantages and disadvantages. Hence the utmost care should be taken that no incorrect assertions are made. The two most important measures proposed by Dr. Woodworth are—first, the erecting of marine hospitals in such cities as New York and Philadelphia, and the abolition of the time-honored practice of boarding sailors in civil hospitals; second, the introduction of physical examinations of merchant sailors. In the discussion of each of these measures there are statements concerning the very vital question,—that of expense,—which we believe can scarcely be sustained.

Thus, in regard to the first, we read (page 9), "This would not add to the cost of the service the amount of salaries of nineteen additional medical officers, as might at first be supposed, as, at ports where medical officers are not stationed, the pay for medical attendance is counted as part of the per diem rate, which embraces the cost of board, nursing, and medicines." We cannot speak for all the ports, but we know that in Philadelphia, and we presume

that in every large city of the nineteen ports, the seamen are treated in large civil hospitals, where there is no pay for medical attendance, and no interest upon the cost of erection; they are taken also at a rate which does not compensate the actual average outlay upon patients. The hospital has to be heated, lighted, and officered whether the sailor is or is not in its wards: hence it is considered economically wiser to receive the marine hospital protégé at a little above the actual cost of the food and medicine consumed than not to receive him at all,—a conclusion clinched usually by the earnest desire of the medical staff to have as wide a range of cases for study as possible.

Under these circumstances it is very obvious that erecting and sustaining hospitals in Philadelphia and similar places would add very materially to the expenses of the service, provided of course the food, etc., were as good in those hospitals as the sailors now receive. Again, in these same city hospitals are found large staffs of the most eminent men of the profession, devoted each to some special branch of medical science; a band whose collective wisdom and skill certainly must be much greater than that of the single marine hospital surgeon, who would unite in his own person all the medical and surgical knowledge and skill available in the proposed hospital.

It certainly is very clear that there are many disadvantages in the proposed change, and the report of Dr. Woodworth fails to make apparent any at all commensurate advantages other than the magnifying of the number and importance of the marine hospital service, and the supporting by government of an increased number of physicians,—the last, indeed, a result, in the present overcrowded state of the profession, devoutly to be prayed for.

The discussion of the second reform urged by Dr. Woodworth is chiefly from the pen of Dr. P. H. Bailhache. Some of the argu-

ments which he brings forward in favor of it are extremely forcible, but chiefest of them all is that which is derived from the greater safety to be secured for vessels with their living and lifeless freight. If it be true that "bad sailors more than bad ships are the causes of losses," then the instinct of self-preservation certainly demands that sailors should be carefully selected, whatever difficulties may lie in the way. These difficulties seem, however, underrated by Dr. Bailhache. To be trustworthy, this examination must be made at least every time a sailor ships, and so we understand the proposition to be. This being the case, does not the following quotation contain an error?

"No expense to the government, to the seaman, or to the vessel attaches to this measure. The machinery for its economic and successful management already exists. The Marine Hospital Service, through its medical officers, can readily assume and perform all the duties required in making such an examination," etc. Now, it is notorious that no marine hospital service at present exists at many of our large cities, and, if it be created, the physician who is occupied with the sick cannot spend his time examining recruits.

How many surgeons would have to be added to the service in New York City alone? It would certainly be unjust to make the hospital fund pay this expense,—especially as the legitimate hospital expenses already are in excess of the receipts, as is shown by the fact that the surplus with which the year 1875 was started has been reduced at the close of 1877 about fifty-five thousand dollars, or, in other words, that during the three years named the annual expenses of the service have exceeded the annual receipts, on an average, eleven thousand dollars.

There is one point of view which, we believe, is not touched in the report of the Supervising Surgeon,—the justice to the individual sailor. The soldier and the

government sailor undergo a rigorous examination when they enter the service, but they are not forced to give up their livelihood when their physical condition begins to be impaired. There is no adequate provision for the merchant sailor when disabled. Often he must pursue his avocation unto death, or become pauperized. Now the question arises exactly at what point of physical disablement has society, represented by the government, the right to step in and say, "Our safety requires that you should be debarred from following the sea. You are used up, and can go to the poor-house, or do the best you can for yourself." It is true that society practically carries out this policy in various dangerous trades, but it enforces judgment not openly, but through what seems to the victim inevitable physical necessity. Surely before the pitiless law crystallizes in black and white upon the statute-book, a much wider and deeper discussion should be had than is afforded by the report of the Supervising Surgeon.

CORRESPONDENCE.

LONDON LETTER.

THE chief matter of medical interest recently has been the annual meeting of the British Medical Association. This, the forty-sixth of the Association, and the third visit to Bath, was not expected to be a monster meeting; nor was it so. It was a moderate gathering numerically and intellectually, except Prof. MacKendrick's demonstrations of acoustics and Mr. Wheelhouse's address in surgery. Bath has seen its palmy days, and is beginning to present evidences of senile decay; yet its magnificent spring will always keep a certain number of people about it. Placed in an amphitheatre of hills, it is a warm, steaming place, and is a capital winter resort; but in August this does not constitute an attraction. Nevertheless, the meeting went steadily to work. The recent death of the outgoing president, Dr. Eaton Wilkinson, of Manchester, deprived us of the pleasure of seeing him vacate the chair in favor of his successor, Dr. Wilbraham Falconer, the well-known physician of Bath, and for years the respected treasurer of the Association. He contrasted the present condition of the Association with what it was when last there, in

1848. Then its transactions were over in two days, there were only 1400 members, and its income was only £1400. Now six days are taken up fully with its annual doings, it numbers 7500 associates, and its income last year was £11,500. (In 1848 it had only the guinea of each subscriber; now there are the advertisements in its journal as a source of revenue.) Out of its present receipts grants can be awarded for the purpose of encouraging scientific research; and Dr. Falconer referred to the work done by the late Prof. Hughes Bennett, by Professors Rutherford and MacKendrick, Dr. Braidwood and others. After reviewing the progress and present position of the Association, the president went on to describe Bath. He said it was a city which was resorted to for its social and educational advantages as well as for its notable spring. Recently remains of Roman architecture, in the form of a large bath two hundred and forty feet in length and one hundred and twenty in breadth, have been found, which attest the fact that at that time the spring at Bath was one of repute and distinction. Athelstan, Edgar, and Osric, Saxon kings, visited Bath and enriched it by gifts of gratitude for the benefits they had received therefrom. This spring is no mite of a thing: it discharges daily no less than 181,440 gallons; and the solid matter discharged in a year amounts to 420 tons, or about one ton and a quarter per diem. It comes up at about an average of 115° F., and is uncomfortably warm to the hand. There is a large and spacious pump-room, with an outpour as from a two-inch pipe, and this steaming fluid is drunk by the visitors in the morning fasting. This water is stimulant especially to the secretions, and acts on the bowels and kidneys. It is apt to produce headache if taken at all freely. In atonic gout the water is very efficacious, but is not suited for acute attacks. In chronic rheumatism it often achieves a cure where all other remedies have failed. There has been established a mineral water hospital for the treatment of gout, rheumatism, and paralysis. The fact, which was clinically observed, of paralysis being relieved by a course of Bath waters, is very interesting, showing as it does the association of paralysis with lithiasis and the condition of arteries and heart found therewith. At the Mineral Water Hospital the Sections on Medicine, Surgery, and Public Medicine were held, and in the room where the Medicine Section held its meeting there is an old picture of a physician and surgeon seeing patients with rheumatic gout, paralysis, and leprosy: the surgeon is feeling the paralytic's left hand very awkwardly, while the right arm hangs helplessly down. The peculiar pallid skin of chronic Bright's disease is very happily caught by the artist, and the man clearly has a clot in Broca's convolution. The thickened joints of a woman are also faithfully

depicted; and a little boy, with a shaven head and a fisherman's woollen cap on, has on his arms an eruption, but what form of lepra I do not know. I asked Mr. Jonathan Hutchinson about it, and he said he would look at it and tell me; but I have had no opportunity of seeing him since this conversation, so cannot in this letter say any more about it. Such, then, are the maladies for which Bath waters are in repute.

Then the secretary read the annual report; and a very satisfactory one it was. He announced that the invitation for the Association to visit Cork next year had been accepted, and Dr. O'Connor, of that city, had been elected president-elect. Seven hundred and odd new members had joined during the year. New branches had been formed; and the first colonial branch had been started in Jamaica. Grants had been voted for scientific research and for the systematic investigation, by a committee, of hydrophobia and rabies. Mr. Middlemore, of Birmingham, had generously given £500, the interest of which shall be awarded triennially for the best essay on the progress of ophthalmic medicine and surgery. A circular had been issued to every board of guardians, asking them to recognize the importance of registering all outbreaks of infectious disease and sending copies of reports to the Registration of Disease Committee. The Association had also taken the most active interest in the medical reform bill recently before Parliament. It is an unspeakable relief to know that this bill has been thrown out this year, and is not likely to raise its head again for some time; and in the interval possibly something like a decent comprehension of the matter may be developed; for, although medical reform has been talked about since the writer was a child, most men seem glad that the different prospected bills have perished *in ovo*.

On Wednesday morning the work went on briskly, the address in the Medicine Section being given by Dr. Goodridge, the senior physician to the hospital. He reviewed our present knowledge of those pyretic processes called "fevers," their causation, the changes set up in the organism, and the consequences thereof. If all this were worked out and known, probably the difficulties in the way of rational treatment would be much reduced. "The doctrine of despair" was to be reprobated, and passivity might well be exchanged for the most active investigation, with advantage. In the afternoon the Sections went to work, and in the Medicine Section a discussion as to the diagnosis and treatment of intestinal obstruction attracted a crowded audience. The only part of the discussion which had any claim to novelty was the advocacy of surgical interference not only in order to unloose twisted folds of gut or unravel a volvulus, but for the purpose of ascertaining exactly the nature and relations of other

obstructions, including malignant growths, and of giving relief by the performance of Amussat's or Littre's operation. The recent experience of ovariologists has shown that exploratory incisions could be made into the abdomen with comparative impunity, especially with antiseptic precautions. We are "not losing our respect for the peritoneum," as Mr. Wheelhouse said, next day, in his surgical address, but certainly we are losing our timidity about interfering with it. The introduction of this feature of a discussion on some special subject is of recent date, and though these discussions have so far brought out nothing original, they enable a large number of the profession to hear the latest words that have been spoken on the subject, by what falls from the various speakers. The ad interim report of the Hydrophobia Committee was then read by Dr. Gowers. In the Surgical Section the papers were all connected with the bones, hip-joint disease, and subcutaneous section or excision, and spinal curvature, especially as to the use of the plaster jacket therein. It must be gratifying to American surgery, and personally pleasing to Dr. L. Sayre, to know how general has been the adoption of his plan of treatment, and the success that has been achieved thereby. In the Obstetric Section a number of papers were read, but none of them were of such interest as to call for any allusion to them. In the Public Medicine Section the papers ran on the compulsory registration of infectious disease; but unanimity of opinion was not attained. The feature of the Physiological Section was the address on Physiological Acoustics, by Professor MacKendrick, of Glasgow, who has recently published an admirable text-book of physiology for the use of students. He pointed out how the increasing rapidity of air-vibrations produced a tone by the use of Helmholtz's siren, and showed how a noise differed from a musical tone, the latter being due to regular vibrations. He then demonstrated how the flame of a gas-jet could be shown by a revolving mirror to be a steady line of light till the note to which each flame corresponded was struck, and then the flame became a series of lambent tongues of light. The lucid exposition of the professor, and his admirable manual dexterity in making his experiments successful, evoked a general request that he would repeat his experiments next day, when a large audience warmly applauded his lecture.

In the evening there was the usual conversation, given by the mayor and citizens, and not by the president and the members of the Association, this year, which was largely attended. Of course there were the geological sections of the city and neighborhood, fossils, prints of Bath in its palmy days, the phonograph and telephone, and a large muster of the aborigines. The girls of the west of England are said to be "poor, proud,

and pretty." As to the two first, nothing may be affirmed; but certainly as to the third attribute there was no positive evidence; but that might be due to the large infusion of outsiders who have come for various reasons to reside at Bath. The original feature was a quantity of Bath waters in bottle,—the first step in an attempt to introduce them into general use. The attempt may be successful, but the water is heavily handicapped as a beverage. It is not palatable even when cold and aerated. It cannot compete with the continental waters either as a beverage on the one hand or as a purgative water on the other. It is not pleasant enough to drink, and most people will prefer something shorter as a purgative. It may be questioned whether patriotism, in its present enfeeblement, will procure a sale for Bath water, unless its reputed stimulant qualities can attain for it a demand among the temperance party.

The usual temperance breakfast, under the presidency of Mr. Samuel Bowley, came off next morning. About one hundred and fifty were present. It may be asserted confidently that such an attendance does not faithfully represent the attitude of the profession, and it is impossible to escape the conviction that the chief factor in such an attendance is that it saves a breakfast in the hotel bill. The next factor is the prospect of some amusement. This year there was not much of the latter, and the only thing said likely to live was the writer's remark, in recommending the temperance body not to oppose the physiologists by stating that alcohol was not burnt in the body, "that the food-value of alcohol taken as a beverage was scarcely worth contending for: that before a man could make a substantial meal of alcohol he would be blind drunk." These breakfasts are useful enough, but there is rather too much of the setting up of teetotalers, not always even medical men, to tell the profession what the right view of the alcohol question is, than a following out of the programme, viz., to ascertain the views of the profession on the subject of the use or abuse of alcohol. Nevertheless, the profession are always glad to see Mr. Bowley on these occasions.

On Thursday morning Mr. Wheelhouse gave the surgical address, which was in every way worthy of him and the Leeds school which he represents. He traced the gradual growth of modern surgery, using illustrative cases from his own experience or that of his colleagues, giving to them that generous credit which is not always accorded to colleagues who are also rivals in practice. It is simply impossible to follow this address, or attempt any abstract of it; but a brief allusion to the last case he gave may be permissible. A man, in crossing a fence with a scythe, got a wound of the buttock, the scar of which is still nine inches in length. The sciatic nerve was completely severed, the

limb was a flail, and he presented himself at the Leeds Infirmary to have the useless encumbrance removed. Dr. Clifford Allbutt found that the muscular susceptibility to the faradaic current was all but extinct. Mr. Wheelhouse cut down and found the nerve-ends two inches apart, with a large ganglion of nerve-matter, etc., on the proximal ending. This was removed, and an attempt was made to approximate the nerve-ends by longitudinal sutures. To achieve this the leg had to be flexed to the utmost, and the ankle strapped to the buttock. Then it became possible to get the ends together. First came back some sensibility, then some motor power, and now the man is able to work for a living, though the injured leg is not yet equal to its fellow.

There was little of interest in the Sections, the most entertaining matter being the discussion on syphilitic neuroses in the Medicine Section. In the evening the public dinner was held, at which were present Dr. Marion Sims, Dr. Daly, of Pittsburg, Dr. W. H. Pancoast, of Philadelphia, Dr. Cleaver, of Keokuk, Iowa, and Dr. J. J. McAngear, of Fort Madison, Iowa. Dr. Marion Sims and Dr. Daly replied for the toast of "The Guests."

On Friday morning the address in Forensic Medicine was given by Prof. Douglass MacLagan, of Edinburgh. After describing how much more forensic medicine was studied in Scotland than in England, he proceeded to contrast the criminal procedure of Scotland with that of England. He upheld the view that it was the duty of the state to prosecute, and he inveighed against the present system in England. In Scotland they had a public prosecutor, while in England the cause of death was ascertained, or attempted to be ascertained, by a coroner,—an officer, he said, of Plantagenet times, who was aided by a jury who were the neighbors of the injured person, and who therefore knew something about the cause of death. He did not approve the modern idea of medical coroners. He thought the lawyer on the bench and the doctor in the witness-box constituted the right men in the right place. He thought English jurisprudence might take a hint or two from the Scotch usefully. Meanwhile the Sections had been going on without much interest, except a paper by Dr. Bell, of Bradford, on wool-sorter's disease. This is a form of acute septicaemia, which may prove fatal in seventeen hours. It occurs when moist wool or alpaca is being sorted, and if the wet bales are allowed to dry, all danger is avoided. The septic particles seem to be inhaled, and, if death is not so rapid, lung-symptoms are developed along with the general condition of septicaemia.

In the afternoon the mayor gave a garden-party in his beautiful grounds on the top of one of the numerous high hills which surround Bath. Some exquisite iced coffee and cream was served out to the guests on their arrival, and after that there followed ices, champagne

cup, and other good things which suit the inner man at the later stages of a week like this. The evening closed by a concert at Colston Hall, Bristol, given by the Bristol doctors, where there was excellent music. A special train ran the medical freight back and forwards. This closed the meeting, and next day everybody was off, either on the excursions or otherwise. But a word or two may not be out of place about Bath in addition to what Dr. Falconer said. Bath is a staid town, and its chief characteristics are propriety and piety. A staidness is seen everywhere. There is religious gravity in the air, as there is moisture in the atmosphere. Its sombre terraces, its serious-looking houses, the numerous tablets in the Abbey, all tell of grave and earnest women: very genteel poverty flourishes there and rules the town council. Respectability and seriousness are the two leading indications of Bath, and this ought to be made the most of. Such concomitants of the spring ought not to be overlooked, then, and in their advertisements on the labels of the newly prepared bottles of Bath waters should be printed, in black type, "the religious watering-place." The people who would be at home at Bath would have little affinity for the light and thoughtless gossipers who congregate at Harrogate and Homburg, who are not only in the world but "of the world." Such being the case, it seemed specially unfortunate that this "city of the sea" should have been chosen as the place where the vote of the Association should be taken as to the admission of women members. If the advocates of their admission ventured to hope that the guardian spirits of Bath would be favorable to their cause and dishearten their opponents, they were very much mistaken. And though the speeches were not very convincing, and Mrs. Garrett Anderson made an eloquent and vigorous speech, the conclusion was evidently a foregone one: the opposition was overwhelming. The ladies have lost the privileges of the membership, and really one does not exactly know whether they should be congratulated or commiserated with: they at least have been saved, even if by their opponents, from being wearied by having to attend the Sections, or being bored by the reports of special committees, and still more from the terrible penance of listening to the after-dinner speeches of the annual banquet. Their lot may be a hard one, they may have been very badly treated; but there are those who think that they ought to draw a long breath of relief at the thought of what they have escaped.

The hospital at Bath, as also the Exeter Hospital, is a century old, of the days of palatial buildings, with the feelings of the architect the great matter for consideration, rather than the form of building best suited for checking the spread of pyæmia. Both hospitals are well ventilated, and kept very clean and free from hospital smell, and the patients looked

well fed and happy, as the denizens of these two rich sunny counties should be.

Instead of joining any of the excursions as usual, and leaving the British Medical Association to go its way, my steps were turned to Wonford House, Exeter, the asylum for the middle and upper classes of Devonshire, Cornwall, Dorset, and Somerset. It took its origin "at a meeting of the grand jury, held at the castle of Exeter, the 16th day of March, 1795, Sir Boucher Wrey, Bart., foreman, in the chair." A subscription was opened and a meeting held on the 29th of July, 1795. Some of the rules then passed contrast the treatment of the insane at that time with their present management very strongly. Rule 2 is, "No patient shall be chained or handcuffed without the previous knowledge and approbation of the physician or apothecary." It is possible to suspect, however, that general orders were often given by the physician or apothecary, for we read another rule, "The physician and apothecary shall visit the asylum every Tuesday morning at twelve of clock, and oftener when any urgent case shall require peculiar care and attention." Now there is a trained medical superintendent resident, and there is not a strait-waistcoat, even, on the premises. Other measures than brutal violence are now found much more efficacious. There is another rule which has an ominous look about it; it runs thus: "that the feet of every patient under confinement or in straw be carefully examined and rubbed and covered with flannel every night and morning during the winter months." This calls up some painful suspicions as to what refractory and excitable patients had to go through in the days of old. Now such things are unknown, even in pauper asylums, to say nothing of the denizens of Wonford House. A beautiful three-story building of ornamental character, it stands about a mile from Exeter, with a range of hills across the Exe facing its front. In its grounds are targets for archery, and hoops for croquet, and the attendants and patients at cricket enjoy themselves famously in the balmy air of South Devon. Inside are drawing-rooms, music, billiards, every home comfort that can make the patient feel the restraint as little as possible. But still beneath this silken glove there is the iron hand. Sitting with a grand old parson, mad as a hatter, but a gentleman withal, I tried to throw the window a little farther up: it successfully resisted my efforts, when the old boy, with a chuckle of much inward satisfaction, said, "Don't you remember you are in a mad-house?" Those windows have nothing repulsive about them, but the suicidal patient has no chance of getting out either of the house or his troubles by the open window. Then the superintendent is a cultured gentleman, who sympathizes with every one of these mad folks and makes their captivity as little galling to them as is possible. We went out

for a drive the other day, with two or three of the poorer patients, whose friends cannot afford drives, with us. There may be a strain of insanity in me, but the insane are far more interesting and entertaining to me than the sane,—infinitely more so. And if ever this latent strain develops into something more pronounced, I trust some connection with the four western counties will be established, in order that Wonford House may be my home during the period of my mental alienation. With these gentle, pleasant Devon patients to associate with, and this thoughtful, able doctor to look after me, insanity and captivity are robbed of half their terrors. In such a place the insane are infinitely better off than at home, even if surrounded by luxuries and kind and sympathizing friends. Gentlefolks carry their training and their evidences of good breeding with them even beyond the portals of an asylum; and the courteous Devonshire people are amiable and lovable even in their madness. Their character harmonizes with their pleasant landscapes, their balmy temperature, their sunny skies, for Devonshire is indeed "the garden of England;" while the beauty of the girls, with their dark locks, their bright eyes, and clear complexions, is linked with a stalwart bearing, manly yet gentle, of the men,—the men truly of Charles Kingsley's "Westward Ho," the crew of the Rose. As I sit at the open window, with the breeze rustling amidst paper and fluttering leaves both of open books and ferns, the prominent feeling is that this place is as near Paradise as man may hope for in his unglorified state. A well-conducted lunatic is the most agreeable of all companions, when the mental aberration is just sufficiently pronounced to give piquancy to the character. The sylvan beauty of the scene, the clear blue sky flecked with white clouds, the inspiring breeze, all conduce to the feeling of inward satisfaction, and raise high the anticipations of pleasure to be derived from an excursion up the Dart with some of these interesting patients as companions. But my letter must come to an end, as these personal details can scarcely be interesting to readers in search of medical details. One item may be pardoned. This morning, as the doctor read the record of his tell-tale clock, his face was clouded for a moment. On inquiring if anything was amiss, he smiled, and said, "No: this is the clock's fault." It must be a very clever tell-tale clock that can indicate its own shortcomings!

J. MILNER FOTHERGILL.

TO THE EDITOR OF THE PHILA. MEDICAL TIMES:

DEAR SIR,—At a recent meeting of the New York Academy of Medicine, Dr. Lewis S. Pilcher read a paper upon the subject of Colles' fracture, the chief point of interest being the theory which he advanced as to the mechanism of the production of this injury.

He rejected the commonly received explanation that the radius, being caught between two counter-forces, gives way at the weakest point, about one-half inch from its lower extremity, but asserted that the force immediately concerned in producing the fracture acted through the medium of the anterior radio-carpal ligament. Forcible extension of the hand being made, this ligament becomes tense, and if the strain is continued, either the ligament must give way or the radius, which is in the position of a bent lever of the first class,—the fulcrum being the posterior surfaces of the scaphoid and semilunar bones,—must suffer fracture.

This was followed by an exhibition of some specimens in which the fracture had been produced in the above manner.

In the discussion which ensued, Dr. Frank H. Hamilton remarked that he was "proud to know that it was an American surgeon who had made the observations, and felt highly honored that the New York Academy of Medicine was among the first medical societies to which these observations had been unfolded." Dr. A. C. Post suggested "that the fracture should be called Pilcher's fracture instead of Colles' fracture." Dr. Willard Parker had "listened with profound interest, and had been much instructed by Dr. Pilcher's paper," etc.

As these distinguished surgeons estimate so highly the value of this explanation of this common accident, it may be interesting to note that substantially the same theory has been taught for years at the University of Pennsylvania by a Philadelphia surgeon. In my notes on the lectures of Prof. D. Hayes Agnew I find that he defines Colles' fracture to be "a transverse fracture of the radius occurring just above the articulation," and says that while "Barton's fracture—or a fracture extending into the joint—is caused by direct pressure of the carpal bones on the posterior rim of the articulating surface of the radius," yet that the conditions in Colles' fracture are different. "In falls on the hand when it is strongly extended, the posterior—not the articular—surfaces of the scaphoid and semilunar bones are driven up against the radius and form a fulcrum. The anterior ligament (radio-carpal) is brought up strongly and with great tension against the front of the articulation, and as it (the ligament) usually resists the force, the solution of continuity takes place at the point to which the strain is transmitted, which is the lower end of the radius, a short distance above the joint."

This explanation is also that given by Dr. Agnew in his "Treatise on Surgery," the first volume of which is now in press and will be shortly forthcoming. If there is any credit in priority in these observations, and if there is any reason for a particular community to feel honored by them, the credit and the honor belong here and not in New York.

Yours truly, J. WM. WHITE.

222 SOUTH SIXTEENTH STREET, August, 1878.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, JUNE 13, 1878.

THE PRESIDENT, DR. H. LENOX HODGE, in the chair.

Cancer of the right kidney—Thrombosis of ascending cava and left renal vein. Presented by Dr. JOHN GUITÉRAS.

HENRY F., a German, æt. 68. Admitted to the Philadelphia Hospital the 27th February, 1878. His legs were swollen, hard, shining. Eight or ten ulcers, about the size of dimes, could be counted on each limb. They were surrounded by a dark purplish skin, showing no tendency to heal. The swelling extended up beyond the popliteal spaces. It was more marked in the left leg. He was anæmic, short of breath, without any thoracic lesion apparent. The gums were spongy, the teeth loose, his diet bad, his residence the out wards of the hospital, where scurvy abounds. As a case of scurvy the man was treated, and improved much. He gained in vigor, in flesh, and in color. The ulcers healed, leaving some indurations. The right leg returned to a normal size, and the left was almost as much reduced. Now it was found that the horizontal position was necessary to keep the legs in this condition. If he stayed up they were sure to swell. Outside of this, and an occasional accident that will be mentioned shortly, he appeared in very good health, had very good color, and was the most cheerful patient in the ward; had no pain whatever; no albumen; no casts in the urine. The belly was large, but nothing that might not be normal. The liver was large, and the superficial abdominal veins were somewhat distended. The heart was fatty, though not to a marked degree. An anæmic murmur at the base disappeared under treatment. While in the wards he had two severe attacks of hæmaturia, relieved by ergot and gallic acid. They left no trace behind.

The third and last attack commenced on the 20th of May. He was in bed, getting over a slight swelling of the legs, brought on by sitting up for two days. I did not see him at this time, but I gather from the notes of Dr. Roberts, the resident physician, that on that day the urine became dark and clotted in the vessel. On the 21st, "Passed no urine in twenty-four hours; bladder rose high up in the hypogastrium; passed a No. 20 catheter, and removed, by aspiration, about two ounces of clots. This was followed by the discharge of about fourteen ounces of bloody urine. In spite of astringents and hypodermics of ergotin the hæmaturia continued. On the 23d the hemorrhage was so

great, and the condition of the patient such that, as a last recourse, Dr. Bruen suggested the injection of a weak solution of Monsel. The hemorrhage was controlled, but the weak pulse did not improve, and he soon commenced to vomit. He continued to pass very small amounts of dark-colored urine."

May 26.—I saw him, and found distinct symptoms of uræmia. He lay unconscious, with stertorous breathing, and occasional twitching of the right side, face, and arm. With the right hand he continually scratched the chest and abdomen. The left side seemed to be paralyzed. There was rotation of both eyes, and slight turning of the head to the right. The face was not engorged. The pulse had become slower and full. The legs were not more swollen, but the superficial abdominal veins were more distended than usually. The temperature was subnormal. He died the same day.

The post-mortem examination revealed a general infiltration of the right kidney, with encephaloid cancer. The organ was uniformly enlarged to the size of a foetal head. There was no cancerous growth elsewhere. The vesical plexus of veins contained coagulated blood. A yellowish, firm, partially-adherent coagulum extended up the internal iliacs and the cava to the level of the renal veins. A firm, loose plug was found obstructing the left renal vein. The brain was anæmic and oedematous. There was no marked atheroma, no hemorrhage, no embolus, no thrombosis.

Remarks.—I am sorry that a more careful examination was never made of this patient. His general condition excluded all idea of abdominal cancer, though the persistent swelling of the feet pointed in this direction, together with the hæmaturia. The theory of scurvy seemed to explain all the symptoms, and an examination of the abdomen was neglected, which would certainly have led to the discovery of the tumor.

I thought that an occlusion of the cava and renal veins was the only condition that could give rise to the symptoms present before death, especially after taking into consideration the injection of Monsel into the bladder. Of course I expected to find that the function of both kidneys had been interfered with by the clot. I also expected to find some obstruction in the cerebral vessels.

In the discussion on the diagnosis of renal enlargement, Dr. Guitéras said that his own and the other cases presented should be used as evidences, not of the impossibility of detecting renal enlargement, but of our neglect to look for it. He was sure that in the great majority of these cases the region of the kidneys had not been examined. He remembered a case where Dr. Pepper had diagnosed, by physical exploration, a nephritic abscess in a case where the symptoms could be well accounted for by an empyema that was also

present on the same side. He thought that palpation gave valuable information as to the size of the kidney. He had found that by frequent percussion he could always satisfactorily map out the organ. Very often in the first examination no results could be obtained, but subsequently one became able to recognize the changes in the conditions of collapse and inflation of the surrounding guts that act as obstacles to the examination.

Colloid cancer of the abdomen. Presented by
Dr. THOS. M. DRYSDALE.

I visited Mrs. Margaret M. Rice, in consultation with Dr. William B. Atkinson, October 30, 1877, to examine a tumor of the abdomen, which was supposed to be ovarian. She gave me the following history of her case. She was thirty-three years old; had always been healthy, except an attack which her medical attendant called "bilious intermittent fever, with liver complaint." This was twelve and a half years since.

She first menstruated when between sixteen and seventeen years old, and had no pain nor trouble of any kind; has always been regular, except when pregnant, until two months ago, when she missed it, and has not menstruated since. Her menses were never accompanied with pain, were normal in amount, and usually lasted two and a half or three days.

She was married when twenty-one years of age, has had three children, all now living, the youngest three years old last May, the next six next month, and the oldest nine the 1st of October. Her labors were perfectly natural and easy. The first was slow, the others quick. She nursed all her children. After marriage she was always troubled with leucorrhœa, often quite profuse.

She has been losing flesh for over a year, and has become greatly emaciated and anæmic. She has had no trouble with her bladder; her bowels are natural in every way; her appetite remains good, and up to this time she has done her own work.

The enlargement was first noticed two years ago, in November, when nursing her child, and just at that time she had an attack of nervous prostration, which her doctor told her was owing to prolonged lactation, and advised her to wean her babe.

The swelling commenced in the centre of the lower part of the abdomen. It was comparatively small till last June, and then rapidly increased, causing her to look "just like a woman in the family way." This rapid growth has continued to the present time.

She has never had pain in the abdomen until two months ago, and then for a short time had severe shooting pains, which were supposed to be owing to an umbilical hernia. She was first attended by Dr. Ruttey, who used electricity. She then went to the University Hospital, where she was examined by

Dr. Goodell and told she had an ovarian tumor. Dr. William B. Atkinson was next called upon, and he, in company with Dr. I. Williamson, tapped her, and obtained about a quart of a jelly-like matter. These gentlemen also diagnosed an ovarian tumor.

I found the abdomen very prominent and enormously distended. A large umbilical hernia existed, filled with fluid, a contraction in the middle causing it to appear double. The abdomen was dull on percussion, except along the region of the ascending colon. The right flank was resonant, the left dull, and along the edge of the ilium semi-resonant. Fluctuation could be detected everywhere, except in the right hypochondriac region. The tumor was smooth, elastic, and immovable. There was neither pain nor tenderness on pressure.

Examined per vaginam, the uterus could be felt low down, with the cervix pushed towards the right side, and pointing that way. The uterus was immovable. The sound entered three inches, and so anteriorly that the handle had to be pressed against the perineum to insert it. The back of the pelvis was filled with hard, fixed masses, which felt like uterine fibroids, and were tender to the touch. The uterus was intimately connected with or imbedded in these growths.

December 8, 1877.—In company with Dr. W. L. Atlee and Dr. Atkinson, I tapped her, and removed about three quarts of a colloid matter, which resembled in color, consistence, and general appearance calf's-foot jelly. There also escaped small quantities of a thin greenish fluid. It required fully an hour to obtain this quantity, although a large canula and trocar were used.

After tapping, the epigastric region and whole upper part of the abdomen became resonant on percussion. On deep pressure, a hard mass could be felt in the left hypochondrium. Palpation gave the sensation as if a stratum of thin fluid existed between the abdominal wall and tumor. The mass could now be moved to a certain extent. My diagnosis was given as colloid cancer of the abdomen, and an operation declined.

The tapping relieved her of the feeling of distention, and on visiting her the next day I found her sitting up. Her color had improved, her lips were red, and she said she felt quite comfortable. Dr. Atkinson now took entire charge of her case. She continued to emaciate, the abdomen enlarged, and in a month or two the umbilicus ulcerated, an opening forming, through which large quantities of colloid substance, and a greenish fluid, were discharged, as much as a bucketful of the last escaping at one time. When I last saw her, June 5, the abdomen had entirely changed in appearance; the lower part had retreated, more especially on the right side, leaving a hard mass filling the entire upper part of the belly, and another

and softer mass the left lower portion. She died June 8, 1878.

Assisted by Dr. W. L. Atlee, Jr., I made an examination of the body June 9. The emaciation was extreme. The abdominal wall was so thin that my first incision penetrated the cavity. The peritoneum was thickened and opaque; its surface was unevenly studded with white deposits, resembling the diphtheritic membrane; the subperitoneal areolar tissue was converted into colloid, forming a layer from an eighth to a quarter of an inch in thickness. There was no organ which had a natural appearance. Filling the epigastric, the right and left hypochondriac, and left lumbar regions was an enormous colloid tumor, which careful examination proved to be the degenerated omentum. When cut, it had the appearance of a honeycomb, the cells or alveoli being filled with a pale-yellow jelly. Below this mass were the small intestines, lying empty, and close to the back. Below these again was a large soft mass filling the hypogastric and right inguinal regions, and stretching far towards the left. When the adhesions of this were detached, it was found to be the right ovary in a state of colloid degeneration. The uterus, which was found below this mass, appeared healthy on superficial examination. The left ovary had degenerated into a single cyst, filled with jelly, which not only occupied the upper portion of the pelvis, but sprang up as a globular tumor behind the uterus. The contents of the abdomen were incorporated into one tumor by this colloid material, and scattered through the gelatinous body could be found masses, varying in size, of the more fibrous or honeycomb-like material. It was a collection of these that were felt during life surrounding the uterus.

I present the specimens, but will not describe them minutely, both to save time, and because the general and microscopic appearance of this form of cancer has been so ably treated of by Sir James Paget in his *Lectures on Surgical Pathology*, to which I would refer you (p. 772). I would merely say that all the specimens I have examined of this disease correspond closely with his description, except, in two instances, the absence of the nucleated cells, which he (after Lebert) describes as lying free in the colloid substance.

The object which I had more particularly in view in bringing these specimens to your notice was to point out the great similarity of symptoms between this form of disease and that of multilocular ovarian tumor. In fact, so closely do they resemble each other that I believe it impossible to distinguish between them during life, except by tapping. This case was diagnosed as ovarian tumor by more than one able physician, and I certainly should have agreed with them before the tapping was performed, but, having met with

these cases before in the practice of Dr. Washington L. Atlee, I was familiar with the jelly-like matter, and so saved from an erroneous diagnosis.

Dr. Atlee, in his great experience of abdominal tumors, has met with but six of these cases, and they were so much alike that a description of one would apply to all, and in nearly all were they mistaken for ovarian disease by their physicians until the tapping revealed their true nature. This colloid or jelly-like material is unmistakable, and once seen can be always recognized.

Case of recurrent fibroid of axilla. Presented by Dr. NANCREDE for Dr. J. ASHHURST, JR.

The tumor was removed from Claude Conrad, aged 21 years, who was admitted, October 11, 1876, to the University College Hospital for encephaloid of the axillary, which diagnosis was revised to sarcoma. Professor Agnew removed the growth on the above-mentioned date, and he was discharged, cured, October 31, 1878. Since that time five other small recurrent tumors have been removed by his family physician in Factoryville. On May 28, 1878, Dr. J. Ashhurst, Jr., removed the present tumor, with two smaller growths, making in all eight tumors removed since the first was excised by Dr. Agnew. Macroscopically, this growth resembles strongly a uterine fibroid, but microscopically was seen to consist of numerous cells of a connective-tissue type, imbedded in a hyaline intercellular substance, presenting no appearance of fibrillation. Some of the cells were becoming decidedly spindle-shaped, evidently developing into fibre-cells.

THURSDAY EVENING, JUNE 27, 1878.

THE PRESIDENT, DR. H. LENOX HODGE, in the chair.

Three cases of heart disease associated with kidney disease. Presented by Dr. JAMES TYSON.

GEORGE C., colored, age 45, native of Philadelphia, occupation barber, was admitted to the Philadelphia Hospital, April 5, 1878, in a very feeble and prostrated condition, frequent pulse, general oedema, and great dyspnoea. He was a very large, stout man. Although his intelligence was perfect, he never was inclined to answer questions. He said he had been healthy previous to his present illness, which had been of but a few weeks' duration; he denied having had rheumatism or syphilis, or having used liquors in excess. Bowels constipated; tongue coated; no appetite; great thirst. Cough with white frothy expectoration. Feet very much swollen; whole body oedematous. Skin dry. Pulse 120, dicrotic. Urine diminished in quantity, and highly colored.

Physical examination.—Area of heart's dul-

ness much increased; systolic murmur at the base; later, also, a mitral systolic murmur was observed. There were moist râles all over the chest and back. Examination of urine revealed albumen in variable quantity at different times, from one-quarter of bulk examined, to a trace; no tube-casts, but often much epithelium from the kidneys, and a great excess of urates.

Diagnosis.—Aortic stenosis and slight mitral insufficiency. He improved for a short time under digitalis and tonics. A jaborandi sweat did not act favorably. Soon his condition grew worse; oedema became more marked; and the patient was compelled to remain in sitting position during the last two weeks on account of excessive dyspnoea. He died May 12, 1878.

Autopsy.—Heart hypertrophied and dilated. Aortic valves slightly atheromatous and stiffened, also fenestrated, but not thickened. Mitral cusps evidently, but not markedly, thickened. Aorta dilated, and highly atheromatous.

Lungs oedematous; some pleuritic adhesion on the left side.

Kidneys enlarged and swollen; in a state of parenchymatous nephritis.

Liver and spleen normal.

Brain not examined.

Remarks.—The most interesting facts in the history of this case are the slight degree of valvular lesion compared with the extreme degree of the symptoms, the marked dyspnoea and excessive dropsy, and the fact that there was also chronic tubal disease of the kidneys, with very few casts.

J. M., colored, age 56, native of Virginia, was admitted to the Philadelphia Hospital four times. First admission in May, 1877, for one week, with the diagnosis of aortic regurgitation. Second admission in July, 1877, when he was transferred to the venereal wards. Third admission in December, 1877, when he remained in the medical wards until March last, under the care of Dr. Guitéras; diagnosis, chronic Bright's disease. Last admission, May 24, 1878, under my own care. When I saw him he was in a very feeble, prostrated condition, frequent pulse, great dyspnoea, and not able to speak.

Physical examination.—Dulness on percussion over the right side of chest; region of dulness changed by change of position of patient. The heart was pushed much to the left side. First sound of heart reduplicated; slight systolic murmur at the base, and also a mitral regurgitant murmur. Dr. Guitéras also found marked dulness over the upper part of sternum; right pulse larger than left.

Examination of urine.—Albumen only a trace; urates in excess; hyaline and some granular tube-casts.

Diagnosis.—Pleuritic effusion; hypertrophy of heart; aortic stenosis and mitral insufficiency; interstitial nephritis. Dr. Guitéras

diagnosed, in addition to this, atheroma and dilatation of the aorta.

Died on June 9.

The *post-mortem* notes read as follows:

Heart.—Hypertrophy without dilatation; walls of left ventricle one inch thick; posterior leaflets of mitral valves thickened, the chordæ tendineæ of left valve much thickened, pulling out the muscoli papillaris, which were extremely hypertrophied and unusually hard. Semilunar aortic valves slightly thickened, and atheromatous. Aorta greatly thickened, and generally atheromatous, and dilated; about one inch from its commencement it became double.

Lungs.—Right lung much engorged and congested, the lower lobe completely consolidated, and entire hemorrhagic infarction. Extreme pleuritic effusion on right side.

Kidneys contracted, not more than three inches long; granular.

Liver, intestines, and peritoneum healthy.

Brain not examined.

Microscopic examination of kidneys confirms an advanced interstitial nephritis.

George J., white, age 35, native of Philadelphia, a laborer, admitted to the Philadelphia Hospital, April 17, 1878. He was a large, strong man, has never been sick, except an attack of rheumatism, which he had in 1871, for a few weeks, and never since. He had syphilis, and has been also a drinking man. His sickness dates only from February last, when he took cold, being one day whilst perspiring very much exposed to snow and cold wind. Had cough, fever, shortness of breath, and pain in the region of the heart. A few days before his admission to the hospital his feet began to swell, the swelling extending later over the whole lower extremities and the scrotum. He did not complain of any pain, but had very great dyspnoea. Appetite good; excessive thirst; quantity of urine diminished—only a trace of albumen; no tube-casts; some epithelial cells from the kidneys, and some blood-corpuscles.

Physical examination.—Area of heart's dulness increased. Marked systolic murmur at the base of heart, and a murmur is heard in the right carotid; a mitral murmur was also observed coincident with the impulse, and transmitted to the axilla. Vocal fremitus diminished at the left side of chest.

Diagnosis.—Mitral insufficiency and aortic stenosis, and chronic pleurisy.

The patient died suddenly and unexpectedly, May 12.

Autopsy.—*Heart* much hypertrophied; cavities much thickened; chicken-fat clot in right auricle. Extensive vegetations on aortic sigmoids, with partial calcareous degeneration of the same. Marked thickening of mitral valve.

Lungs.—Hypostatic congestion of both lungs; pleuritic adhesions on left side.

Kidneys large, swollen; capsule strips off

easily. Left kidney with marked hemorrhagic infarctions; in both kidneys minute hemorrhages over the surface. Cortex increased. Microscopic examination reveals a parenchymatous nephritis, with capillary congestion and extravasation of blood.

Dr. GUITÉRAS said that at a previous meeting he had referred to several cases where he had succeeded in diagnosing slight dilatation of the aorta by means of respiratory percussion. In some of the cases the diagnoses have been since that time confirmed by autopsies. This had led him to attach much importance to the systematic use of this method of percussion for examination of the aortic region. He made it a rule never to examine this region without percussing at the end of a forced expiration. As the lungs collapse over the large blood-vessels, it is surprising to find how clearly the area of dulness of a dilated aorta becomes apparent.

The first case he had examined after this manner was one where aneurism had never been suspected, and where no dulness could be obtained by ordinary percussion, yet he was enabled to demonstrate to a large class an area of almost flatness over the right border of the sternum, above the third rib. Slight pulsation could also be seen towards the end of expiration. Other symptoms have developed since, leaving no doubt as to the diagnosis.

In Case No. II., a colored woman, 38 years old, the symptoms of pressure on the trachea were well marked. Symptoms of vascular disease rendered it probable that the source of pressure was an aneurism, but the dulness at the upper piece of the sternum could only be detected at the end of forced expiration.

In Case No. III., an old woman, there were evidences of valvular disease, both mitral and aortic. The aortic systolic murmur was so feeble (weak ventricle) that the existence of lesion of the semilunar valves had been doubted. By respiratory percussion the presence of aortic dilatation was demonstrated, and the diagnosis was subsequently confirmed at the post-mortem.

Of Case No. IV. no notes had been kept. During life the enlargement of the vessel could only be demonstrated at the end of expiration. Diagnosis confirmed by the autopsy.

Case No. V. was the one now before the Society. When this case was admitted early this year in the wards of Dr. G. at the Philadelphia Hospital, he supposed it to be one of contracted kidney with cardiac hypertrophy. But his attention was called to examine the aortic region by a prominence of the right sterno-clavicular articulation. This had nothing to do with the aortic lesion, but pulsation at the base of the neck was noticed, with inequality of the radial pulses. Respiratory percussion led to the discovery of a well-marked area of dulness.

Case No. VI. was examined previous to these investigations, but it is mentioned because though the dilatation was not greater than in some of the cases just described, yet it could be detected by ordinary percussion. The emaciation of the patient probably accounts for this. She died of cancer of the uterus.

Case No. VII. was seen only yesterday, after a prolonged absence in Cuba. In 1876 Dr. G. had found evidences of disease of the aortic valves and of atheroma of the arteries in its early stage. During the same year he saw him, in consultation with Drs. Alonzo Clark and Austin Flint, of New York, and Dr. Landeta, of Havana. Dr. Flint confirmed the diagnosis, but Drs. Clark and Landeta suspected the existence of some dilatation of the arch. Dr. Clark based his diagnosis upon evidences obtained by ordinary percussion. Now the patient presents all the symptoms of aneurism of the ascending portion of the arch. It is very probable that respiratory percussion would have made the lesion more apparent in its incipency. Curiously enough, at present, when there can scarcely be any doubt of the existence of an aneurism, the percussion resonance over the aortic region is but very slightly impaired, and is not influenced by respiration. This is due, Dr. G. believes, to adhesions fixing the lung.

He also desired to call attention to the value of pulsation of the neck, as being a very conspicuous symptom in cases of aortic disease, both of the valves and vessel. It should always lead to a careful examination of the aortic region. In differences between the carotid pulses and in unilateral thrill pretty strong evidence is found of disease of the aortic arch. Of seven cases presented, five had unequal radial pulses. In No. II. this symptom was absent; in No. IV. it was not looked for.*

Unfortunately, the specimen of double aorta was removed from the body before the anomaly was noticed. At the first glance it was difficult to determine whether the double aorta was not a dissecting aneurism. There was a slit about an inch beyond the left subclavian artery leading into the accessory aorta. The latter ran up to the subclavian, forming a pouch, and downwards as far as the mutilated specimen shows. Further examination leaves no doubt as to this point: the edges of the slit are smooth, the lining membrane of the anomalous channel has the normal appearance, and, most important of all, the orifices of the left intercostal arteries are seen in the outer wall of the false aorta; the right intercostals arise from the main vessel near the septum; in the latter some aborted orifices may be found.

* All these cases will be published more in detail, together with observations on the normal respiratory percussion of the aortic region.

As a point bearing on the pathogenesis of atheroma, it may be mentioned that, whilst the arch of the aorta is well dilated, and, together with the rest of the main channel, is highly atheromatous, yet in the accessory aorta, where the blood-pressure must have been much less, there is scarcely any atheroma.

Cancer of the ascending colon. Presented by
R. G. CURTIN.

John McL., æt. 64 years, married, native of Scotland.

The patient, who was by occupation a stone-cutter, came under observation on the 15th of January, 1877.

When he was 21 years old, he had an attack similar to the one for which he came under treatment last January, except that he did not then notice any tumor at the seat of pain. This seizure passed by, but kept him so reduced that he was for a time unable to work.

In the early part of 1876 he had some rheumatic symptoms in the legs, and suffered from weakness and vertigo.

With these exceptions the patient stated that he had been perfectly well up to within eight months of the time he applied for treatment.

In the month of June, 1876, while lifting a heavy stone, he suddenly felt a stinging or *jagging* sensation, of a warm or burning character, in the right iliac fossa, which continued for two weeks, sufficiently severe to unfit him for work.

About two months after this lift, his attention was directed for the first time to a tumefaction in the right iliac fossa, at the point in which he had felt the sensation of pain. This tumor was somewhat tender on pressure, becoming more so as it increased in size. The patient compared the pain to that of an abscess, as if matter were present.

In August he had a great tendency to nausea, and frequently vomited. For a month or two only he belched up "wind and slime." When swallowing food he noticed an inclination to eructation. He would feel the gas working up and down, and obtained temporary relief after belching.

Never passed blood with his stools. Bowels were regularly opened until about October, 1876, when first symptoms of constipation appeared.

He would go to stool with flatulent colicky pains, and fail to be relieved. Suffered much from *rumbling* in the bowels, accompanied with pain.

When first seen, in January, 1877, he had coughed for two months, expectorating about a tablespoonful in twenty-four hours.

Auscultation revealed, on the left side, noisy and harsh inspiration, with audible and prolonged expiration, about the mammary region; on the right side in the correspond-

ing region harsh and noisy inspiration, with expiration same as on the left side.

There was progressive loss of flesh and strength, and the patient died, on the 18th of May (last), of exhaustion and starvation. There was extreme emaciation.

Post-mortem.—On opening the abdomen, a tumor, the size of the fist, was found about one-third of the way up the ascending colon. The only evidence existing of peritonitis was a small patch outside the tumor, where a loop of the upper part of the ascending colon was bent down and attached to the tumor. The tumor was hard, and on section the tissue grated under the knife like cartilage. The inside of the tumor was in an ulcerated state, with patches of red, pulpy mucous membrane scattered here and there. The alimentary canal was patulous through the tumor, but very much constricted.

The difficulty in making a diagnosis in this case from chronic perityphlitis is apparent from several considerations. First, he had stated that he had had a soreness, with evidence of inflammation, in the same place when a boy. Second, the soreness came on suddenly after a heavy lift. The growth was very slow, and ceased a year before death.

A daughter of this man had an ulcerated condition of the small intestine, seated near the same place, two years ago. The specimen was presented to this Society.

Dr. Seiler made a microscopic examination of the tumor, and found the muscular tissue of the intestine at the place of the new formation to have disappeared; in its place a connective tissue forming alveoli, in which were epithelial cells, was found.

Dr. TYSON said in reference to one of the symptoms mentioned by Dr. Curtin, the sensation "as if something had suddenly given way" within the abdominal cavity, that he thought this symptom was due here to the rupture of an adhesion, which had formed at a previous period, when inflammation first set in, due to the irritation of the growing mass. Some years ago he had met the same symptom in the case of a young man, who, while gunning, felt something give way in the abdomen as he made a long leap; immediately peritonitis was developed, and he died promptly.

Embotic pneumonia. Verbal communication by Dr. GUITÉRAS.

Dr. GUITÉRAS desired to relate very briefly a case bearing upon the discussion of embolism. He had found at the Philadelphia Hospital a pair of lungs presenting numerous small patches of gangrene. He had immediately suspected the existence of some focus of infection, since the tissue between the foci was healthy. On asking, it was discovered that the man had had during his rather short illness a dark and fetid discharge from one ear. The body was placed again upon the

table, and the skull was opened. A portion of the petrous portion of the temporal bone was found broken down, and the lateral sinus near it in a condition of gangrene; its walls and the contained clot presented a greenish hue, and were fetid. The body had not commenced to decompose. The emboli washed from this focus were evidently infectious, and they gave rise to a process similar to the one taking place at the fountain-head. The patient was a robust adult.

REVIEWS AND BOOK NOTICES.

HANDBOOK OF OPHTHALMOLOGY. By Prof. C. SCHWEIGGER, of the University of Berlin. Translated from the Third German Edition by PORTER FARLEY, M.D., of Rochester, New York. J. B. Lippincott & Co.

It has not been so very long since medical science passed through the dangerous crisis in which a vague and fantastic speculation threatened to carry all before it. The general necessity of placing upon a firm basis the educational standard of a proper scientific method of obtaining knowledge, only by close and careful observation and study, has driven away empiricism. This has become evident in the several branches of the animal functions and economy, by the new ideas already opened, and the lucidity given to many intricate points hitherto considered obscure.

The science of medicine is one of practical truths; therefore its progress, to be near the truth, must be kept far removed from all speculation which is not well supported by immediate observation and experience.

Until within a short time the attention of students has been drawn, in relation to medicine and surgery, to general matters only; while the special parts have been neglected, or rather skipped over. But, thanks to a divine order, the development has been so great that the different parts and organs of the human body have undergone especial observation, with the result of calling attention to the necessity of their separation into different branches for particular study, thus giving rise to specialties in the practice of our profession. In none of the branches has there been more activity in the development of really scientific and practical results than in that of ophthalmology. For the past twenty-five years it has been the great study throughout Europe and the United States, and new brochures and books upon subjects relating thereto are continually issuing,—so much so that, as Prof. Schuh remarked upon another matter, "they have become 'massenhaft.'"

In all the different handbooks and treatises on ophthalmology we must expect to have many repetitions on the same subject, but at the same time we gain more fully the partic-

ular experience of each individual writer than in any other way; and the greater the experience the greater will be the gain to the reader and student. As in the case before us, Dr. Schweigger was for many years connected with the late v. Graefe as ophthalmoscopist in his large clinic in Berlin, and had with him an experience of great and lasting benefit. After the death of v. Graefe, he was appointed to fill his place as Professor of Ophthalmology in the University of Berlin, and surgeon in charge of the Ophthalmological Department in the Charité Hospital.

As a handbook is but a short manual of reference, it is not to be expected that we will find everything taken up and exhaustively treated. It is the purpose only of the author to call attention to the general matters in ophthalmology, and to enlarge upon the more important points, so as to give a good insight into the many different affections with sufficient information to enable the physician to diagnose the different forms of diseases and their treatment, as well as a foundation for pursuing his studies deeper and more thoroughly in this branch if so desired.

It is written in a short, concise, and very readable style, making it interesting and well calculated to prevent the reader from becoming wearied. Everything that the author deems necessary to explain is clearly and plainly elucidated in the briefest but most comprehensive manner, making it a valuable book for the busy practitioner. He excludes everything that would be of interest only to those who desire to make a special study of ophthalmology.

The translation is well done, the clear concise language of the original having been admirably preserved. It is, however, much to be regretted that he did not also act as English editor, and bring the contents up to the standard of the present day, by inserting in notes the many new and important points in relation to the pathology, treatment, and operations since the issue of the German work; for we find nothing new since 1874, and then only two references for that year. Really there are but ten references to new matters since the first edition in 1871.

The book is gotten up in most excellent style, with good paper and print, and is well worthy a place in the library of every physician, for reading and ready reference.

DISEASES OF THE NERVOUS SYSTEM. By SAMUEL WILKS, M.D., F.R.S. Philadelphia. Lindsay & Blakiston.

This is a well-written book of nearly 500 pages, containing little or nothing that is novel, but yet not lacking in the freshness which arises from the author having seen and studied at the bedside what he is talking about. It covers very fairly the field of nervous diseases, and we recommend it cordially as a guide to those who want to get a sufficient knowledge

of the subject for use in ordinary practice, but are unwilling or unable to give the time required by some of the more extensive works.

GLEANINGS FROM EXCHANGES.

UNUSUAL OCCURRENCE IN THE ATTEMPT TO REDUCE A DISLOCATED HUMERUS (*The Lancet*, July 6, 1878).—Mr. Thomas Smith reports the following very rare and interesting case, premising it with the remark that the gentleman who made the extension was not an athlete, nor was he supposed to possess any extraordinary physical force, neither had he put out his entire strength at the time of the accident: "A man, aged fifty-eight, was admitted to the hospital April 30, 1877. Eight weeks before admission he fell on his elbow, his hands being in his pockets at the time. As the result of this accident he suffered from paralysis of the radial nerve, and his arm lost its ordinary mobility, for which he was treated in various ways. On examination at the time of his admission he was found to have suffered a subcoracoid dislocation of the left humerus, which had escaped notice. On May 3, with the concurrence of the surgical staff of the hospital, he was put under the influence of ether, and after Mr. Smith had manipulated the limb so as to break down recent adhesions, an attempt was made to reduce the dislocation. The house-surgeon, sitting on the ground by the side of the patient, placed his left foot, covered only by a thin sock, in the axilla; a jack-towel was fastened by a clove hitch round the arm just above the elbow, the other end of the towel being passed behind the house-surgeon's shoulder, who also made extension by pulling from the patient's wrist. No other force was employed, and no assistance was given by bystanders. After extension had been maintained for a minute or so, the whole of the anterior fold of the axilla, integuments and muscles, gave way like 'rotten leather.' The cavity of the axilla was laid widely open, and pretty free hemorrhage took place. This was at once arrested by pressure, the patient was lifted on to the operating-table, the bleeding vessels were secured, the axilla was washed out with carbolic solution, the wound was partially closed, and drainage established by lint soaked in carbolic lotion.

"The pectoral muscles were found to have been almost completely torn, and the large vessels and nerves, with the head of the humerus, were laid bare, but not torn; the dislocation was reduced with ease. No immediate constitutional disturbance followed the accident. The patient took his food well, and his temperature was normal for four days; but as the discharge set in, his strength began to fail, and he died on the ninth day, from exhaustion.

"On post-mortem examination, diffuse supuration was found to exist in and around the axilla, and the parts about the upper and middle lobes of the right lung were in a state of consolidation. The heart was flabby; the liver large, pallid, and fatty; the kidneys normal; the spleen large, soft, and semi-fluid; vessels of the size of the tibials were rigid from calcareous degeneration. The muscles generally were paler, softer, and more flabby than normal. At the seat of injury nothing could be ascertained as to their condition as regards degeneracy, owing to the amount of sloughing that had taken place. No microscopical examination was made."

OPIMUM HABITUATION (*The Medical Record*, July 27, 1878).—Dr. J. B. Mattison, of Parish Hall, Brooklyn, an institution exclusively devoted to the treatment of the victims of the opium-habit, details some cases coming under his notice, and thus summarizes the principles of treatment there adopted. Tonics and sedatives constitute the therapeutic reliance. The effect of preliminary *sedative* treatment in obviating the discomfort of the withdrawal of the opium is so satisfactory that we are most firmly convinced of its value.

Bromide of sodium is preferred for its pleasanter taste. It is given, largely diluted, three—occasionally four—times in the twenty-four hours. The plan of frequent and prolonged administration—thirty to sixty grains every half-hour, etc.—is not regarded with favor. The effect of the bromide being rather remote, this method incurs the risk of recharging the system and entailing unpleasant if not serious results.

The efficacy of hot baths has been alluded to. Their value is beyond dispute.

For removal of the muscular debility we have found nothing equalling general faradization, twenty minutes séances daily. The sense of exhilarating comfort resulting is very decided.

Strychnia is always employed with cod-liver oil, phosphorus, iron, digitalis, and quinine, as the case may demand; and out-of-door exercises, especially pedestrian, with varied social enjoyments, form valued adjuncts in treatment.

Our experience proves conclusively the efficacy of therapeutical resources in overcoming this formidable disorder, and warrants a favorable prognosis in all cases not complicated by organic disease.

THE ACTION OF SULPHURETTED WATERS IN REPRODUCING THE SYMPTOMS OF SYPHILIS WHEN LATENT (*The Practitioner*, July, 1878).

—The explanation of the effects of sulphuretted waters in reproducing the symptoms of syphilis is stated by Güntz as follows: 1. A decomposition of albumen is produced by the water. 2. This decomposition is expressed clinically by a transitory chlorotic condition, owing to diminished size of the liver and spleen, and by increased excretion of urea.

3. This increase of urea is due to the action of the sulphuretted water in withdrawing oxygen, the effect of which is increased by coincident diminution of the activity of the heart and respiration. 4. The formation of new syphilitic products is effected at the cost of metamorphoses of albuminous substances, which by their decomposition produce new conditions, under which the syphilitic poison can act and form new combinations. 5. As long as the capacity of syphilitic contagion to attach itself to organic elements exists, so long can the poison remain in the body. Mercury acts in the same way as sulphuretted water, since it forms an albuminate in the body.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U. S. ARMY FROM AUGUST 25 TO SEPTEMBER 7, 1878.

KING, WILLIAM S., LIEUTENANT-COLONEL AND SURGEON.—Assigned to duty at Carlisle Barracks, Pa. S. O. 156, Department of the East, August 31, 1878. Granted leave of absence for six months, on account of sickness, with permission to apply for an extension, if necessary. S. O. 190, A. G. O., September 2, 1878.

SIMONS, J., LIEUTENANT-COLONEL AND SURGEON.—Assigned to duty at Fort McHenry, Md. S. O. 156, c. s., Department of the East.

HEAD, J. F., LIEUTENANT-COLONEL AND SURGEON.—Assigned to duty at Fort Independence, Mass. S. O. 156, c. s., Department of the East.

McPARLIN, T. A., MAJOR AND SURGEON.—Assigned to duty at Fort Hamilton, N. Y. H. S. O. 156, c. s., Department of the East.

FRYER, B. E., MAJOR AND SURGEON.—Granted leave of absence for twenty-two days. S. O. 153, Department of the Missouri, August 26, 1878.

McCLELLAN, E., MAJOR AND SURGEON.—When relieved by Assistant-Surgeon Gray, to proceed to Fort Lapwai, Idaho, and report for duty at that post. S. O. 104, Department of the Columbia, August 22, 1878.

NOTSON, W. M., MAJOR AND SURGEON.—When relieved by Assistant-Surgeon Koerber, to comply with S. O. 176, c. s., A. G. O. S. O. 176, Department of Dakota, August 20, 1878.

BROWN, H. E., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for one month, with permission to leave the Department. S. O. 181, Department of Texas, August 26, 1878.

BARTHOLOF, J. H., CAPTAIN AND ASSISTANT-SURGEON.—Relieved from duty at Camp Harney, and assigned to duty at Fort Stevens, Oregon. S. O. 104, c. s., Department of the Columbia.

KOERPER, E. A., CAPTAIN AND ASSISTANT-SURGEON.—Assigned to duty at Fort McKinney, Wyo. T., relieving Major Notson. S. O. 77, c. s., Department of Dakota.

CLEARY, P. J. A., CAPTAIN AND ASSISTANT-SURGEON.—Leave of absence extended one month. S. O. 65, Division of the Missouri, August 26, 1878.

STEINMETZ, WM. R., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for one year. S. O. 186, A. G. O., August 28, 1878.

GRAY, W. W., FIRST LIEUTENANT AND ASSISTANT-SURGEON.—Assigned to temporary duty at Fort Vancouver, W. T. S. O. 104, c. s., Department of the Columbia.

BRECHEMIN, L., FIRST LIEUTENANT AND ASSISTANT-SURGEON.—Assigned to duty as Post-Surgeon at the new post to be established near Camp "J. G. Sturgis" (Bear Butte, D. T.) by Major Lazelle, First Infantry. S. O. 102, Department of Dakota, August 27, 1878.

CAMPBELL, A. B., CAPTAIN AND ASSISTANT-SURGEON.—Died at Chicago, Ill., on September 1, 1878.